

VENEREAL DISEASE, SEX POSITIONS, AND HOMOSEXUALITY*

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Statistics in the United States and many European countries show an increasing incidence of early infectious syphilis, and some centres report that the homosexual contributes 80 to 85 per cent. of the total. Physicians and other health workers are evolving techniques to deal with this situation, one of which seems to be a close interrogation of the patient as to the manner of the contact. Published and other reports of venereal infections in suspected homosexuals reflect this, the reports being liberally laced with such words as "active, passive, fellatio, pederasty, etc." The detailed mechanics of sexual gratification of the heterosexual at the time of contracting a venereal disease are not routinely elicited. If this is so, then what is the particular value in having the information from the homosexual?

The common explanation given for determining mode of exposure is that it helps the physician in his search for a possible primary lesion. Apparently he gives greater attention to the sites (genitalia, anus, mouth), which such a history may suggest. However, all mucocutaneous areas can be the site of secondary lesions, *i.e.* condylomata lata, mucous patches, etc., irrespective of the location of a primary lesion. This concept of selective physical examination reaches its extreme when heterosexual contacts are given only a blood test when they deny signs of early syphilis, but homosexual contacts are subjected to complete physical examinations irrespective of other factors.

The homosexual commonly shows a diversified pattern of sexual practice which does not routinely permit a classification of "active, passive, fellatio, etc.". Most do not have such strong preferences that the circumstances of the encounter or the wishes of a particular partner could not dictate the nature of the exposure. During the actual contact, we find varied approaches in eliciting erotic stimulation, with the

partners changing roles at will. Popularly, the sex act is defined as occurring at the time of ejaculation. Forgotten is the infected pre-ejaculatory discharge or oral mucous membrane, which may have deposited organisms on a number of susceptible areas scattered over the body, any one of which feasibly could be the initial infection, rather than the ejaculatory site. The self-acknowledged homosexual, like his heterosexual counterpart, finds that certain sexual positions have greater social acceptance than others, and this will influence his willingness to discuss them. As a result, he may give his interrogator an apparently satisfactory answer, which is in fact inaccurate or completely erroneous. Social attitudes are reflected in the state sex laws, which in effect categorize heterosexual as well as homosexual relations. As an example, for the latter group, California provides maximum prison sentences of 15 years for oral copulation, but life for anal intercourse (California Penal Code, 1959, Section 288A and 286).

There is another aspect to such detailed history-taking which discounts any theoretical advantage in acquiring the information. This is the reaction of the patient. Understandably, many homosexuals have varying degrees of guilt feelings about their activities. These may be further aggravated by the contraction of a venereal infection. Such feelings stand in the way of seeking periodic and routine examinations for venereal disease, as well as reducing cooperation in treatment and follow-up regimes.

A comfortable and competent medical atmosphere is essential. At the time of diagnosis of the disease in an infectious stage, epidemiological information must be secured, but many homosexuals find it quite difficult to admit that their contacts are of the same sex. By stressing the value of such epidemiological information, and pointing out how

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discreetly and confidentially it is handled, it is possible to get most patients to cooperate in this type of history-taking. The justification of elucidating the intimacies of sex play may not be clear cut. The patient may interpret this as unnecessary prying or morbid curiosity. Such an unfortunate attitude can destroy proper rapport and thus limit the patient's ability to handle his venereal disease problems.

Summary

Questioning homosexuals about sex position adds little to the value of syphilis diagnosis; it can even be misleading and so defeat syphilis control measures. The fact that physicians feel competent to handle heterosexually-acquired syphilis without

detailed analysis of pre-coital activity and the sex act supports this thesis. By keeping the mind, and therefore, the eyes, open to all variants of sexual activity, whatever the physical examination can contribute to a diagnosis will be secured.

Les maladies vénériennes, les postures sexuelles, et l'homosexualité

RÉSUMÉ

L'interrogation au sujet des postures sexuelles n'ajoute rien au diagnostic de la syphilis chez les homosexuels, et les réponses fausses peuvent même empêcher les mesures antivénériennes. La plupart des praticiens se chargent du traitement de la syphilis hétérosexuelle sans analyse particularisée du coït. Si l'examen physique est fait avec la pensée et les yeux ouverts à tout espèce d'activité sexuelle, rien ne manquera au diagnostic.